MRC | London Institute of Medical Sciences

Imperial College London

Referral for MRI examination

Robert Steiner Unit

For Researcher to complete **mandatory fields (if no ICHNT number)*

Participant Surname: * ....

Participant Forename: * ....

DOB: * ____/____/________

ICHNT Hospital Number (in known): ....

NHS Number (if known): ....

Sex: * ☐ Male ☐ Female

Participant Address: * ....

....

....

Participant Postcode: * ....

GP Name: * ....

GP Address: * ....

....

....

GP Postcode: * ....

Have they lived in the UK for more than 12 months?

☐ Yes ☐ No ☐ Not known

Ethnicity:

☐White ☐Black ☐Asian ☐Other

Study Name: ....

Ethics Number: ....

Participants Study Number: ....

Participant Type: ☐ HVol ☐ Patient

Researcher Name: ....

PI: ....

Date of scan: ____/____/________

Image Format required:

☐ Dicom ☐ Nifti

Spectroscopy Format required:

☐ Dicom ☐ rda

For Radiographer to complete

Anonymisation code:

Exam Completed: ☐ Yes ☐ No

Patient Movement: ☐ None ☐ Low ☐ High

Archiving Completed:

☐Tigris ☐Pacs ☐MRS rda ☐DVD #:..............

Contrast Agent: ☐ Yes ☐ No

Type: ....

Dose: ....

Batch: ....

Expiry: ....

Comments:

Radiographer Name: ....

Date: ____/____/________

Signature: ....